AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient:______________________________________ Date of Birth___/___/___

Address:____

City:____________________________ State:__________ Zip:__________

Date Records Requested:___/___/___ Date Records Released:___/___/___

I, the undersigned, at my request, authorize:

Dr. James Denito, DC
408 N. Allen Dr.
Allen, TX 75013-2500
Telephone: 972-727-8947 Fax: 214-495-0891

to obtain my medical/health records from the following source/address:

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Phone:____

My request for this particular release of medical records includes the following specific records over the dates listed:

____

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The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature:_________________________________ Date:___/___/___
or
Parent/Guardian Signature:_____________________________________
Relationship:_____________________________ Date:___/___/___

I hereby acknowledge I have the right to revoke this authorization anytime in writing, and this specific authorization expires:___/___/___

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*